



# CHEMICAL DEPENDENCY/MENTAL HEALTH/ CRIMINAL JUSTICE SYSTEM MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

Consent for the Release of Confidential Information about Mental Health and Alcohol or Drug Treatment

I, \_\_\_\_\_ authorize (1) The Department of Corrections  
and \_\_\_\_\_

(2) the following <u>Mental Health Treatment Provider</u> : <b>Name:</b> _____ <b>Address:</b> _____ <b>Phone Number:</b> _____	(3) the following <u>Alcohol or Drug Treatment Provider</u> : <b>Name:</b> _____ <b>Address:</b> _____ <b>Phone Number:</b> _____
(4) the following <u>Designated Chemical Dependency Specialist (DCDS)</u> : <b>Name:</b> _____ <b>Address:</b> _____ <b>Phone Number:</b> _____	(5) the following <u>other provider of information</u> necessary for cross-systems communication: <b>Name:</b> _____ <b>Address:</b> _____ <b>Phone Number:</b> _____

To communicate with and disclose to one another the following information (The client must initial each type of information authorized):

<b>(1) Department of Corrections</b> <input checked="" type="checkbox"/> Pre-Sentence Investigation <input checked="" type="checkbox"/> Judgment and Sentence <input checked="" type="checkbox"/> Criminal History <input checked="" type="checkbox"/> Risk Assessment <input checked="" type="checkbox"/> Compliance with Supervision <input checked="" type="checkbox"/> Conditions of Supervision <input checked="" type="checkbox"/> Mental Health Assessments <input checked="" type="checkbox"/> Violations of Terms of a Court Ordered Treatment	<b>(2) Mental Health Treatment</b> <input checked="" type="checkbox"/> MH Treatment Discharge Summaries <input checked="" type="checkbox"/> MH Treatment History and Progress Reports <input checked="" type="checkbox"/> Involuntary Treatment History/Records (RCW 71.05) <input checked="" type="checkbox"/> MH Intake and Treatment Plans <input checked="" type="checkbox"/> Psychological Evaluations <input checked="" type="checkbox"/> Psychiatric Evaluations <input checked="" type="checkbox"/> Forensic Discharge Review (State Hospital) <input checked="" type="checkbox"/> MH Treatment Discharge Summaries
<b>(3) Chemical Dependency/Substance Abuse Treatment</b> <input checked="" type="checkbox"/> Chemical Dependency Assessments and Treatment Plans <input checked="" type="checkbox"/> CD Treatment History and Progress Reports <input checked="" type="checkbox"/> CD Treatment Discharge Summaries <input checked="" type="checkbox"/> CD Treatment Continuing Care Plan <input checked="" type="checkbox"/> Treatment Compliance Reports (Requested by DOC) <input checked="" type="checkbox"/> Request to Designated Chemical Dependency Specialist (DCDS) for an Assessment <input checked="" type="checkbox"/> Chemical Dependency Assessments and Treatment Plans <input checked="" type="checkbox"/> Involuntary Treatment History/Records (RCW 70.96 A)	<b>(4) Designated Chemical Dependency Specialist (DCDS)</b> <input checked="" type="checkbox"/> Violations of a Treatment Order or Condition of Supervision that relates to Public Safety <input checked="" type="checkbox"/> Information about a Petition for Involuntary Commitment  <b>(5) Other:</b> Specify other information as necessary for cross-systems collaboration: <input type="checkbox"/> _____

**The purpose of the disclosures authorized in this consent is:**

(1) To improve public safety by allowing communication and multidisciplinary case management and release planning.

(2) To enable treatment providers to communicate continuing care plan referrals to the above agencies

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164. I understand that this authorization shall remain in effect for the duration of my DOC supervision unless revoked prior to that time. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

☐ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment, or

☐

(Specify other time when consent can be revoked and/or expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

<b>Signature of Offender/Client:</b>	
<b>Initials:</b>	<b>Date:</b>
<b>DOC Number:</b>	<b>Date of Birth:</b>
<b>Co-signature of Parent/Guardian if Offender/Client is under the age of 18</b>	

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2 and 45 CFR Parts 160 and 164. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.